



Victorious Beginnings Behavioral Center

“Caring for Clients one Service at a time”

Please fax or call your client referral to 702-794-1699 or email to VictoriousBeginnings@live.com.

REFERRAL INFORMATION

We accept Fee for Service Medicaid and Self-Pay.

Date of Referral: _____

Client’s Name: _____ DOB: _____ Sex: Male Female

Street Address: _____

City: _____ State _____ Zip _____

Home Phone#: _____ Cell Phone #: _____

Work Phone#: _____ Work Address: _____

Primary Insurance Company: _____ Insurance ID #: _____

Referral Source: _____ Referral Phone Number: _____

Reason for Referral:

Current Concerns:

If you are a PCP or other Referring Provider, Please complete the information here.

Provider Name _____ Phone # _____

Fax # _____

Referral Reason

IMPORTANT: This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability Act (HIPPA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential, and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (number listed above) to arrange the return or destruction of the information and all copies.

Are you requesting that a specific provider see this client? Yes No

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